Form NFBT
(Rev. 1/96)

Nursing Facility Bed Tax
Quarterly Report

Quarter ending _____/_____/_____ Federal ID #_____

Name & Address of Nursing Facility _____

_____

_____

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	A Bed Days Available	B Bed Days Occupied	C Bed Days Medicaid	D Bed Days Medicare	E Bed Days Other	F Bed Days Private Pay
1. First Month						
2. Second Month						
3. Third Month						
4. Quarter Total						

5. Total Bed Days Subject to Tax (Total line 4 column B)
   Column B must equal total of Columns C, D, E, & F _____

6. Total Tax (line 5 X $2.80) _____

7. Adjustments (explain on back of form) _____

8. Total Tax Remitted (Line 6 + 7)

Signature of Person Preparing the Return Phone Number

Instructions: Prepare statement in duplicate. Retain duplicate in company files for audit purposes. Statement and remittance for any tax due must be postmarked on or before the 30th day following the end of each calendar. If you have any questions, please call or write.

Business Tax Section
Montana Department of Revenue
P.O. Box 5835
Helena, MT 59604
(406) 444-1945